

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3426

CERTIFICATE OF DEATH

Reg. Dist. No.

03378

1. PLACE OF DEATH o. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Rock Hall		c. LENGTH OF STAY IN 1b adult life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home - Piney Neck		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bernice Middle B. Last Ashley		4. DATE OF DEATH Month Mar. Day 14 , Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/7/1870
9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 7 Days 8 Hours 9 Min.	11. IF UNDER 24 HRS. Hours 9 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY retired	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William A. Baldwin		14. MOTHER'S MAIDEN NAME Martha Swindells	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Bernice Edwards		Address Rock hall, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO (c) Atherosclerosis (Sclerosis)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 - 1955 to March 4, 1960 , that I last saw the deceased alive on March 14, 1960 , and that death occurred at 10 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Norbert C. Nitsch		ADDRESS (Street, city or town, state) Rock Hall, Maryland DATE SIGNED 3/15/60	
PHYSICIAN'S NAME (Type) Norbert C. Nitsch			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/60	
22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.		22d. LOCATION (City, town, or county) (State) Nr. Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE MAR 17 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

3415 CERTIFICATE OF DEATH

Reg. Dist. No.

03379

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital				d. STREET ADDRESS X Kennedyville		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ethel Middle S. Last Black				4. DATE OF DEATH Month 3/ Day 28 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/2/89	
9. AGE (In years lost birthday) 71 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Indiana		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Oscar Spurgin				14. MOTHER'S MAIDEN NAME Bell Reynolds			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-20-9205		INFORMANT Address Ethel S. Black			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 Congestive Heart Failure DUE TO (b) Right side Heart Failure DUE TO (c) Mitral Disease							INTERVAL BETWEEN ONSET AND DEATH 1 WK. years. years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 3/22 , 19 60 , to 3/28 , 19 60 , that I last saw the deceased alive on 3/28 , 19 60 , and that death occurred at 9:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Thomas J. Solon				M.D. _____			
PHYSICIAN'S NAME (Type) Thomas J. Solon				Chestertown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/31/60		22c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery		22d. LOCATION (City, town, or county) (State) near Fairlee Kent Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE APR 1 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/58

Now 4/15/60
3072162XV4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3416

CERTIFICATE OF DEATH

03380

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Anne Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>LOEN</u> Last <u>BLACK</u>		4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/12/60</u>
9. AGE (In years lost birthday) yrs. <u>1</u> Months <u>1</u> Days <u>19</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Black</u>		14. MOTHER'S MAIDEN NAME <u>Fredia W Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Chestertown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extreme dehydration and electrolyte loss</u> <u>571.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>Diarrhea or Enteritis, cause unknown</u> DUE TO (c) <u>5 days</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/12/60</u> , 19 <u>60</u> to <u>3/2/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/2/60</u> , 19 <u>60</u> , and that death occurred at <u>1:20A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown Md</u> DATE SIGNED <u>3/2/1960</u>			
ACTUAL SIGNATURE <u>Robert W. Farr</u>		M.D. <u>Chestertown Md</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT W. FARR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/2/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Coleman Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>RFD Worton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Walker</u>		ADDRESS <u>Chestertown, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAR 3 '60</u>		DATE <u>3/2/1960</u>	
24b. REGISTRAR'S SIGNATURE <u>Ciriling J. Farris</u>			

103301

STATE OF TEXAS
CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

03381

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Massey		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Massey	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALBERT Middle L. Last CUMMERFORD		4. DATE OF DEATH Month March Day 3 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May, 17, 1890
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic, Boat Yard		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Cummerford		14. MOTHER'S MAIDEN NAME Katherine Dixon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-03-3572	
17. INFORMANT Willis Cummerford,		Address Millington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart atoque (acute) 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic heart decompensation DUE TO (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH Sudden - 6 years 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 22, 1959 , to March 3, 1960 , that I last saw the deceased alive on Feb. 16, 1960 , and that death occurred at 4:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Elza Koralewski M.D.		ADDRESS (Street, city or town, state) MILLINGTON MD	
PHYSICIAN'S NAME (Type) ELZA KORALEWSKI		DATE SIGNED March 3. 60.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 6, 1960	22c. NAME OF CEMETERY OR CREMATORY Massey Cemetery	22d. LOCATION (City, town, or county) (State) Massey, Kent Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Hellman		24a. REC'D BY REGISTRAR MAR 8 '60	
ADDRESS Millington, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kinn	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3428

CERTIFICATE OF DEATH

03382

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETTERTON</u>		c. LENGTH OF STAY IN 1b <u>20</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CATHERINE MAY DEDMAN</u>		4. DATE OF DEATH <u>March 22 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 3, 1876</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VET. ADMIN.</u>	
11. BIRTHPLACE (State or foreign country) <u>BETTERTON, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EBEN WELSH CREW</u>		14. MOTHER'S MAIDEN NAME <u>ALEXANDRIA LAURA LOUISE OWENS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES IWWI</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>LOLLA O. CREW</u> Address <u>BETTERTON, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accidents</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>moderate hypertension</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>53</u> , to <u>Mar</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>March 19</u> , 19 <u>60</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Florence Deringer Joyce</u> M.D.		ADDRESS (Street, city or town, state) <u>WORTON, Md</u> DATE SIGNED <u>3-22-60</u>	
PHYSICIAN'S NAME (Type) <u>Florence Deringer Joyce</u>		<u>Worton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-25-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Still Pond Cemty</u>	22d. LOCATION (City, town, or county) (State) <u>Still Pond, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u> ADDRESS <u>Still Pond, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 24 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles J. K...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3417

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Ann's Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thelma Luverne Gillum		4. DATE OF DEATH March 13 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1916
9. AGE (In years lost birthday) yrs. 43		10. IF UNDER 1 YEAR Months Days Hours Min. 5 months	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Percy Hite		14. MOTHER'S MAIDEN NAME Lola Boor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Informant	
17. ADDRESS Hospital records, Chestertown, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of the liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-6 , 1960 , to 3-13 , 1960 , that I last saw the deceased alive on 3-13 , 1960 , and that death occurred 9:50p M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 3-13-60			
ACTUAL SIGNATURE A.C. Dick M.D. 3-13-60			
PHYSICIAN'S NAME (Type) A.C. Dick, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 17, 1960	
22c. NAME OF CEMETERY OR CREMATORY Millington Cemetery		22d. LOCATION (City, town, or county) (State) Millington, Kent Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward J. Holloway		24a. REC'D BY REGISTRAR DATE MAR 17 '60	
24b. REGISTRAR'S SIGNATURE Arthur J. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3412 CENTRAL AVE. ON DEATH



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1912

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3418 CERTIFICATE OF DEATH

64614

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X	
3. NAME OF DECEASED (Type or print) Eugene C. Gland First Middle Last		4. DATE OF DEATH Mar. 31, 1960 Month Day Year	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/1897
9. AGE (In years lost birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY various	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Douglas Gland		14. MOTHER'S MAIDEN NAME Laura Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW 1		16. SOCIAL SECURITY NO. 220-12-2244	
17. INFORMANT Violet Gland		124 Box Cross St. Chestertown, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congestive Heart Failure DUE TO (b) Hypertension & Pneumonia DUE TO (c) Pneumonia & Pyelitis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.		INTERVAL BETWEEN ONSET AND DEATH 4 DAY year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/28, 1960 , to 3/31, 1960 , that (I) (we) last saw the deceased alive on 3/31, 1960 , and that death occurred at 6:20 P. M., from the causes and on the date stated above.			
22a. SIGNATURE Thomas J. Solon		22b. ADDRESS Chestertown, Md.	
22c. PHYSICIAN'S NAME (Type) THOMAS J. SOLON		22d. ADDRESS Chestertown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/4/60	
23c. NAME OF CEMETERY OR CREMATORY Janes Cem.		23d. LOCATION (City, town, or county) (State) Chestertown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walley		25a. REC'D BY REGISTRAR APR 6 '60	
ADDRESS Chestertown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

County of _____

City and Town of _____

Decedent's Name _____

Age _____

Sex _____ Race _____

SSN _____

Birth Date _____

Birth Place _____

Marital Status _____

Occupation _____

Usual Residence _____

Signature of Physician
Responsible for Death

Signature of Registrar

Date of Death _____

Time of Death _____

Place of Death _____

Signature of Coroner or Medical Examiner

Signature of Registrar

Signature of _____

Signature of _____

Signature of _____

Signature of _____

3419

CERTIFICATE OF DEATH

Reg. Dist. No.

03384

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Queen Anne's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Hill			
				d. STREET ADDRESS 17X-2			
3. NAME OF DECEASED (Type or print) First Frank Middle Covington Last Green				4. DATE OF DEATH Month 3 Day 28 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/4/83	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Green				14. MOTHER'S MAIDEN NAME Mary Elizabeth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213 12 5447			
17. INFORMANT Eleanor Dixon, daughter				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive heart failure DUE TO (c) Arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH 3-4 days 4 years years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3-28 27 , 19 60 , to 3-28 , 19 60 , that I last saw the deceased alive on 3-28-60 , 19 60 , and that death occurred at 9: PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 3-29-60							
ACTUAL SIGNATURE Harry Paul Ross M.D.							
PHYSICIAN'S NAME (Type) HARRY PAUL ROSS, M.D.				203 N. Queen St, Chestertown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/31/60		22c. NAME OF CEMETERY OR CREMATORY Church Hill		22d. LOCATION (City, town, or county) (State) Church Hill Md	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane				ADDRESS Church Hill, Md.		24a. REC'D BY REGISTRAR DATE APR 5 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kneiss			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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James D. Dixon, Editor

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3429 CERTIFICATE OF DEATH

03385

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chestertown		c. LENGTH OF STAY IN 1b 30 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION at home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Gsell Last		4. DATE OF DEATH Month March Day 18 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 17, 1869
9. AGE (In years lost birthday) 91 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY owner	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA (Nat)	
13. FATHER'S NAME Don't Know		14. MOTHER'S MAIDEN NAME Don't Know	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
INFORMANT W. Henry Gsell Address Chestertown, Md. Son			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 422.1 DUE TO (b) Cardio Vascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Arterio Sclerosis (Senility) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 - 19 60 , to March 18 19 60 , that I last saw the deceased alive on March 18 19 60 , and that death occurred at 6:00 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Norbert C. Nitsch		ADDRESS (Street, city or town, state) Rock Hall, Md. DATE SIGNED 3/20/60	
PHYSICIAN'S NAME (Type) Norbert C. Nitsch			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 21, 1960	
22c. NAME OF CEMETERY OR CREMATORY Greensboro Cem.		22d. LOCATION (City, town, or county) (State) Greensboro, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Willis Wells ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR MAR 22 '60 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

STATE OF NEW YORK
CERTIFICATE OF DEATH

73902

3420

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUDLERSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENT - QUEEN ANNE'S HOSP</u>		d. STREET ADDRESS <u>17X-2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES RAYFIELD JARRELL</u>		4. DATE OF DEATH Month Day Year <u>MAR 23 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 24 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES JARRELL</u>		14. MOTHER'S MAIDEN NAME <u>MARY CATHERINE BUSTEED</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNK</u>		16. SOCIAL SECURITY NO. <u>HOSPITAL CHART.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>570.2</u> DUE TO <u>INTESTINAL OBSTRUCTION & GANGRENE</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAR 22</u> , 19 <u>60</u> , to <u>MAR 23</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>MAR 23</u> , 19 <u>60</u> , and that death occurred at <u>2:30</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>CHESTERTOWN, Md.</u> DATE SIGNED <u>3/23/60</u>			
ACTUAL SIGNATURE <u>C. J. Keefe</u>		M.D. <u>ARTHUR T. KEEFE, JR. MD</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR T. KEEFE, JR. MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR 26, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CHESTERFIELD CEM. CENTREVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward J. Hellows, Millington, Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 28 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

10300

CERTIFICATE OF DEATH

1. Name of deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of death: Jan 15, 1910

5. Place of death: Home

6. Cause of death: Heart Disease

7. Signature of physician: Dr. J. A. Smith

8. Signature of registrar: Wm. H. Brown

9. Date of registration: Jan 16, 1910

10. Place of registration: Boston

3421

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> c. LENGTH OF STAY IN lb <u>life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Anne Hosp</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> d. STREET ADDRESS <u>Rt. #1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Oris</u> Middle <u>Lee</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>3</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-28-60</u>
9. AGE (In years lost birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>40</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Kent</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wakefield Joseph Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Louise Lisco</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal Atelectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <u>1 hour 40</u> <u>?</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/28/60</u> , 19 <u>60</u> , to <u>3/28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/28</u> , 19 <u>60</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u>			
ACTUAL SIGNATURE <u>Thomas J. Solon</u>		DATE SIGNED <u>3/28/60</u>	
PHYSICIAN'S NAME (Type) <u>Thomas J. Solon</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/29/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Shaptown Col. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>nr. Rock Hall, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bennett W. W. W.</u>		ADDRESS <u>Chestertown, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAR 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>	

2072324XV0

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3430 CERTIFICATE OF DEATH

03388

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Massey				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Massey X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ANDREW WOODALL JONES				4. DATE OF DEATH Month Day Year March 3 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 24, 1881	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Feed and Grain Dealer		10b. KIND OF BUSINESS OR INDUSTRY Retailer		11. BIRTHPLACE (State or foreign country) Cecilton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas T. Jones				14. MOTHER'S MAIDEN NAME Rachel E. Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-18-5947A		17. INFORMANT Julian H. Jones,		Address Massey, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 weeks years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. p. m. Month, Day, Year 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 2 , 19 60 to 3 Mar , 19 60 , that I last saw the deceased alive on 3 Mar , 19 60 , and that death occurred at 8:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wallace Openshain M.D.				ADDRESS (Street, city or town, state) Cecilton, Md.		DATE SIGNED 7 Mar 60	
PHYSICIAN'S NAME (Type) WALLACE OPENSHAIN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 7, 1960		22c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery		22d. LOCATION (City, town, or county) (State) Cecilton, Cecil Co; Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Holloway				ADDRESS Meltington, Md.		24a. REC'D BY REGISTRAR MAR 9 '60	
				24b. REGISTRAR'S SIGNATURE C. J. S. H. H.			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3431

CERTIFICATE OF DEATH

Reg. Dist. No.

03389

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Joseph T. Jones		4. DATE OF DEATH Month March Day 5 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1895
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painting	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William C. Jones		14. MOTHER'S MAIDEN NAME Jennie M. Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W. War 1		16. SOCIAL SECURITY NO. 212-12-3255	
17. INFORMANT Mrs. Edna Jones,		Address Millington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Rupture 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Orbital Polymia		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) W	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1957 1960 , to July 5, 1960 that I last saw the deceased olive on July 3, 1960 , and that death occurred at 5 P M , from the causes and on the date stated above.			
ACTUAL SIGNATURE C. H. METCALFE M.D.		ADDRESS (Street, city or town, state) 741 3/7/60 DATE SIGNED	
PHYSICIAN'S NAME (Type) C. H. METCALFE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 9, 1960	22c. NAME OF CEMETERY OR CREMATORY Millington Cemetery	22d. LOCATION (City, town, or county) (State) Millington, Kent Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edna Jones		ADDRESS Millington, Md.	
24a. REC'D BY REGISTRAR DATE MAR 9 '60		24b. REGISTRAR'S SIGNATURE C. H. METCALFE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director.
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 48 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JENNIE E. JONES		2. SEX F		3. AGE 45		4. DATE OF BIRTH JAN 15 1880		5. PLACE OF BIRTH BALTIMORE, MD		6. OCCUPATION HOUSEWIFE	
7. MARITAL STATUS MARRIED		8. DATE OF MARRIAGE JUN 15 1905		9. NAME OF SPOUSE JOHN J. JONES		10. NAME OF FATHER JOHN J. JONES		11. NAME OF MOTHER JENNIE E. JONES		12. PLACE OF DEATH BALTIMORE, MD	
13. DATE OF DEATH JUN 15 1925		14. TIME OF DEATH 10:30 AM		15. PLACE OF DEATH HOME		16. CAUSE OF DEATH HEART DISEASE		17. DISEASE OR INJURY CORONARY ARTERY DISEASE		18. MEDICAL HISTORY HYPERTENSION	
19. SIGNATURE OF PHYSICIAN J. J. JONES		20. SIGNATURE OF WITNESS J. J. JONES		21. SIGNATURE OF DECEASED JENNIE E. JONES		22. SIGNATURE OF SPOUSE JOHN J. JONES		23. SIGNATURE OF FATHER JOHN J. JONES		24. SIGNATURE OF MOTHER JENNIE E. JONES	

10051

10051

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3432 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03390

1. PLACE OF DEATH a. COUNTY KENT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Betterton c. LENGTH OF STAY IN 1b 15 yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Betterton d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cornelia First A. Middle Kettlewell 4. DATE OF DEATH March 22 Month Day 1960 Year		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Oct. 26, 1886 9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Harford Co., Md. 12. CITIZEN OF WHAT COUNTRY?		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
13. FATHER'S NAME John Haviland 14. MOTHER'S MAIDEN NAME Ellen M. Ford		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Mr. Earl Haviland Address 6808 Old Harford Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown, but probably natural causes. Manner of death appears to resemble cardiac death. Probably sudden DUE TO Was last seen alive nite of 3/22/60. Was found dead in her home about 5:00 PM 3/22/60. Examination of body failed to disclose any evidence of cause of death DUE TO but she was with on floor beside a bed. She was in bed indicating she had been on it. There were no signs of injury PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Robert W. Farr EXAMINER'S NAME (Type) Robert W. Farr		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 22, 1960 DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Mar. 26, 1960 22c. NAME OF CEMETERY OR CREMATORY Loudon Park 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland.		23. FUNERAL DIRECTOR'S SIGNATURE H. H. Meador, Sr. ADDRESS 805 N. Calvert Street 24a. REC'D BY REGISTRAR MAR 28 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		65		M		W		JAN 10 1940		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
1234 E. BALTIMORE ST.		Carpenter		High School		Married		Heart Disease		Natural	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF ENTRY INTO STATE		DATE OF ENTRY INTO COUNTRY		DATE OF ENTRY INTO STATE		DATE OF ENTRY INTO COUNTRY	
JAN 10 1875		BALTIMORE, MD.		JAN 10 1900		JAN 10 1900		JAN 10 1900		JAN 10 1900	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
JAN 10 1940		BALTIMORE, MD.		JAN 10 1940		BALTIMORE, MD.		JAN 10 1940		BALTIMORE, MD.	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
JAN 10 1940		BALTIMORE, MD.		JAN 10 1940		BALTIMORE, MD.		JAN 10 1940		BALTIMORE, MD.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3433

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03391

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Golt		c. LENGTH OF STAY IN lb 3Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Golt			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle John Last Miller				4. DATE OF DEATH Month March Day 18 Year 19 60			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 17, 1885	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75		IF UNDER 24 HRS. Hours 75 Min. 75			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) A.M.E. Minister		10b. KIND OF BUSINESS OR INDUSTRY Church		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sepio Miller				14. MOTHER'S MAIDEN NAME No Record			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 220-34-6654		17. INFORMANT Mrs. Wm. John Miller Address Golts, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown but probably natural causes DUE TO Deceased had not been under care of a physician. He Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. had not been apparently ill. Death occurred about 11:30 DUE TO P.M. 3/18/60. (b) don't know (c) 795.4							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE Robert W. Farr				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Robert W. Farr, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3/28/60		22c. NAME OF CEMETERY OR CREMATORY Golt Cemetery		22d. LOCATION (City, town, or county) (State) Golt, Va. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward S. Mallow ADDRESS Mallington Md.				24a. REC'D BY REGISTRAR DATE MAR 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3422

CERTIFICATE OF DEATH

03392

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Campus Ave		d. STREET ADDRESS Campus Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle Barwick Last Olliffe		4. DATE OF DEATH Month Mar. Day 1 Year 1960	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1908
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Andelot Farms	
11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph B. Olliffe		14. MOTHER'S MAIDEN NAME Rose Bowers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 222-20-2071	
17. INFORMANT Jos. B. Olliffe, Jr.		Address Crumpton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 15 minutes			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 51 , to Mar. 1 , 60 , that I last saw the deceased alive on Mar. 1 , 19 60 , and that death occurred at 9:15A , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert W. Farr</i>		DATE SIGNED 3/2/60	
PHYSICIAN'S NAME (Type) Robert W. Farr		ADDRESS (Street, city or town, state) Chestertown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 3, 1960	
22c. NAME OF CEMETERY OR CREMATORY Kennedyville Cem.		22d. LOCATION (City, town, or county) (State) Kennedyville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i>		24a. REC'D BY REGISTRAR DATE MAR 3 '60	
ADDRESS Chestertown, Md.		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Frank</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3423

CERTIFICATE OF DEATH

Reg. Dist. No.

03393

1. PLACE OF DEATH a. COUNTY Kent MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 3 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's			d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First John Middle Fletcher Last Price			4. DATE OF DEATH Month 3 Day 7 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/3/83		9. AGE (In years last birthday) 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. of America
13. FATHER'S NAME William B. Price			14. MOTHER'S MAIDEN NAME Elizabeth WATTS (last name unknown).		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (none)	INFORMANT Address Marie Price, Still Pond, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 3-5-60 Several yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 3-4- 19 60 , to 3-7- 19 60 , that I last saw the deceased alive on 3-7- 19 60 , and that death occurred at 9 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE A.C. Dick		ADDRESS (Street, city or town, state) DATE SIGNED Chestertown, Maryland 3-8-60			
PHYSICIAN'S NAME (Type) A.C. Dick					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-10-60	22c. NAME OF CEMETERY OR CREMATORY STILL POND CEMT		22d. LOCATION (City, town, or county) (State) STILL POND, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy		ADDRESS STILL POND, MD.		24a. REC'D BY REGISTRAR DATE MAR 9 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Kenna

072

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1925

CERTIFICATE OF DEATH

State of New York

County of

City of

Age

Sex

Occupation

Married to

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John

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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 03394
 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b XRural Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hosp.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First R. Middle Woodall Last Robinson		4. DATE OF DEATH Mar. 13, 1960 19 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1881
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY owner	
11. BIRTHPLACE (State or foreign country) Queen Anne Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William C. Robinson		14. MOTHER'S MAIDEN NAME Martha Woodall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-34-9208	
17. INFORMANT Mrs. Woodall Robinson		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 DAY years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bleeding Peptic Ulcer 1 ulc			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/27 19 60 to 3/13 19 60 , that (I) (we) last saw the deceased alive on 2/13 19 60 , and that death occurred at 2/27 M, from the causes and on the date stated above.			
22a. SIGNATURE Thomas J. Solon		22b. DATE SIGNED 3/15/60	
22c. PHYSICIAN'S NAME (Type) Thomas J. Solon		22d. ADDRESS Chestertown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/16/60	23c. NAME OF CEMETERY OR CREMATORY Crumpton Cemetery	23d. LOCATION (City, town, or county) (State) Crumpton, Md.
24. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		25a. REC'D BY REGISTRAR DATE MAR 17 '60	
ADDRESS Chestertown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535



TO : DIRECTOR, FBI (100-330)

FROM : SAC, NEW YORK (100-330)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

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100. [Illegible]

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03395

3434

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall (Edesville)		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William A. Thompson		4. DATE OF DEATH Mar. 30, 1960	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/9/1904
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 55	11. IF UNDER 24 HRS. Hours 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Masonry	
11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown XXXXXXXXXXXXXXXXXXXX		14. MOTHER'S MAIDEN NAME Minnie Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Informant	
17. ADDRESS Mrs. Ivory Warren Rock Hall, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 422.1 DUE TO Cardiovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Ischemy DUE TO (c) Cerebral Ischemy		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1, 1960 to March 30, 1960 , that I last saw the deceased alive on March 29, 1960 , and that death occurred at 6 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Norbert C. Nitsch		ADDRESS (Street, city or town, state) Rock Hall, Md. DATE SIGNED 3/31/60	
PHYSICIAN'S NAME (Type) Norbert C. Nitsch			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 2, 1960	
22c. NAME OF CEMETERY OR CREMATORY Sharptown Cem.		22d. LOCATION (City, town, or county) (State) near Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR APR 4 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Fries	

STATE OF OHIO
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
COLUMBUS, OHIO

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TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3425

CERTIFICATE OF DEATH

Reg. Dist. No.

03396

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 17 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William Bullitt Vincent				4. DATE OF DEATH Month Day Year 3 11 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/9/99	
9. AGE (In years lost birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? U.S. of America	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus driver				10b. KIND OF BUSINESS OR INDUSTRY Public Transportation			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S. of America			
13. FATHER'S NAME Charles Vincent				14. MOTHER'S MAIDEN NAME Emma Wallace			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214 10 8636			
17. INFORMANT Helen B. Vincent, wife				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PANCREAS DUE TO 157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 6 mos.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from FEB 17 , 19 60 , to MAR 11 , 19 60 , that I last saw the deceased alive on MAR 11 , 19 60 , and that death occurred at 9:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md 3-11-60 DATE SIGNED Arthur T. Keefe, Jr., M. D., FACS							
ACTUAL SIGNATURE Arthur T. Keefe, Jr.				M.D. Chestertown, Md			
PHYSICIAN'S NAME (Type) Arthur T. Keefe, Jr., M. D., FACS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/13/60			
22c. NAME OF CEMETERY OR CREMATORY Chester Cem.				22d. LOCATION (City, town, or county) (State) Chestertown, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Willis Wells				ADDRESS Chestertown, Md.			
24a. REC'D BY REGISTRAR MAR 14 '60				24b. REGISTRAR'S SIGNATURE Arthur T. Keefe			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3435

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03397

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Chestertown				c. LENGTH OF STAY IN life life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At home Morgnec				e. STREET ADDRESS 1 Morgnec			
3. NAME OF DECEASED (Type or print) First John Middle Wilson Last Wilson				4. DATE OF DEATH Month Mar. Day 4, Year 1960			
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 14, 1894	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	10. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY owner		11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas R. Wilson				14. MOTHER'S MAIDEN NAME Annie Naylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Don't know		17. INFORMANT Elwood Wilson Address Bigwoods RFD Worton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 795.5 IMMEDIATE CAUSE (a) Unknown but probably natural causes DUE TO Deceased had been well for many years. He was last seen alive the A.M. of 3/4/60 at which time he was likewise in good health, apparently. He was found dead in his home by a neighbor on the evening of 3/4/60. He is not known to have suffered from any illness nor had he consulted a physician for many years. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b), STATING THE UNDERLYING CAUSE (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 3/4/60. He is not known to have suffered from any illness nor had he consulted a physician for many years.							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Worton, Md.		20g. (County) Worton, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/7/60			
EXAMINER'S NAME (Type) Robert W. Farr		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/10/60	22c. NAME OF CEMETERY OR CREMATORY Bigwoods Cem. RFD		22d. LOCATION (City, town, or county) Worton, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Welby		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE MAR 11 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

